DOCUMENT RESUME

ED 294 660 PS 017 326

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TITLE Developmental Consequences of Child Abuse. Selected Papers Number 52.
INSTITUTION Foundation for Child and Youth Studies, Kensington (Australia).
REPORT NO ISBN-0-947193-03-0
PUB DATE Jun 86
NOTE 23p.; Based on paper presented at a seminar at the Royal North Shore Hospital, June 1986.
PUB TYPE Viewpoints (120) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Child Abuse; *Emotional Problems; Family Characteristics; Foreign Countries; *Incidence; *Individual Development; Psychotherapy; *Sexual Abuse
IDENTIFIERS *Australia (New South Wales); Projection (Psychology); Research Results; Retrospective Studies (Psychology); *Symptoms

ABSTRACT

This exploration of the dynamics and developmental consequences of child abuse begins with a definition of child abuse and a discussion of child sexual abuse. After a description of the incidence of child abuse, the consequences of abuse--including health and emotional problems, and neuro-developmental disabilities--are discussed. Further discussion focuses on abused children and their families, and findings of retrospective studies of abused children. Concluding sections cover sexual abuse and its possible short-term psychological symptoms and sequelae. Material from case studies supplements the discussion. It is concluded that the reasons parents mistreat their children have less to do with character and temperament than with the possibility that they themselves were mistreated and were not permitted to defend themselves as children. (RH)

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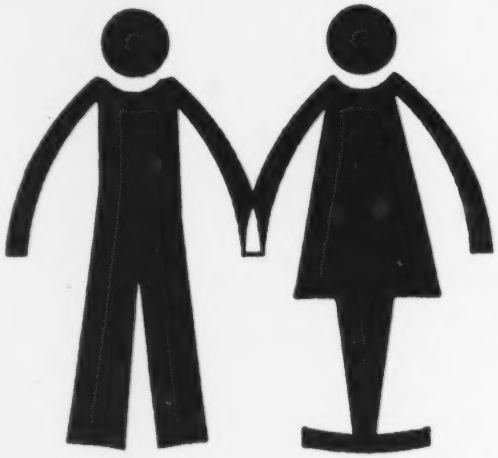

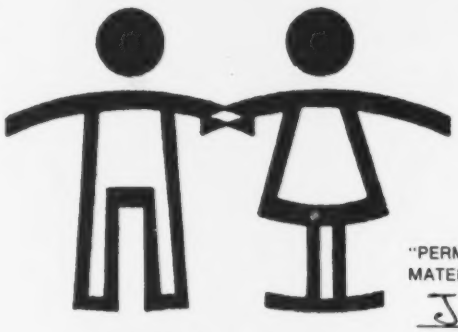

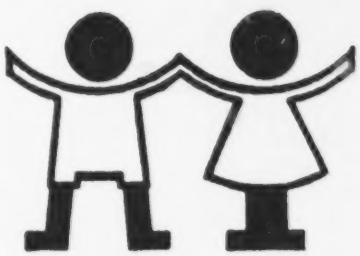

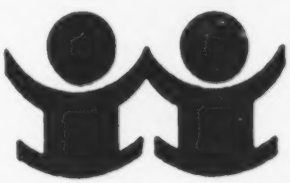

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DEVELOPMENTAL CONSEQUENCES OF CHILD ABUSE

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ISSN 0727-6834

ISBN 0 947193 03 0

DEVELOPMENTAL CONSEQUENCES OF CHILD ABUSE

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INTRODUCTION

The title seems straightforward. But the wish that I could present some clear outline of consequences belies the very great difficulty in doing so. What I would like to do is to present some collage of information that I hope is not too vague or indigestible, that includes some clinical experience of my own and that introduces a variety of well known authors in the field whose work you may be familiar with or may like to pursue further.

Perhaps the logical place to start is with some history. The opening paragraph of Lloyd de Mause's *History of Childhood* (1974) can perhaps set the scene .... "The history of childhood is a nightmare from which we have only recently begun to awaken. The further back in history one goes, the lower the level of child care, and the more likely children are to be killed, abandoned, beaten, terrorized and sexually abused".

Historians in the past failed to notice this pattern, he feels, because serious history has long been considered a record of public not private events. "Historians have concentrated so much on the noisy sandbox of history, with its fantastic castles and magnificent battles, that they have generally ignored what is going on in the homes around the playground." He suggests that where historians usually look to the sandbox battles of yesterday for the causes of those of today, a number of authors in his book combine to ask a different question. They ask how each generation of parents and children creates those issues which are later acted out in the arena of public life. De Mause puts forward a psychogenic theory of history in which he feels that the evolution of parent-child relations constitutes an independent source of historical change. The origin of this evolution lies in the ability of successive generations of parents to regress to the psychic age of their children and work through their own anxieties at that age in a better manner the second time they encounter them. The process is similar to psycho-analysis, which also involves regression and a second chance to face childhood anxieties.

In other words the child becomes a powerful unconscious pull back into ones own childhood experience and it is here that there is opportunity for reworking or growth or alternatively abuse along a continuum from emotional to direct physical and sexual damage.

In this way the dynamics involved in and the developmental consequences of child abuse are inextricably linked. In other words, an unconscious repetition of ones own childhood experiences is felt by many to be the central factor in child abuse. This may help explain why, as Oates (1982) points out, public awareness of the problem is only a recent event, despite the fact that physical and sexual abuse have been features of society for centuries. The stepping stone to awareness was the pioneering work of Kempe and others on physical abuse in the 1960s and sexual abuse in the 1970s.

Such public awareness represents a developmental advance in society contributed to by technological and economic factors, but perhaps more importantly by the recognition, particularly by Freud and others, of the unconscious dimensions to human development and relationships, and the powerful way in which early childhood experience influences later attitudes towards ones own or others' children.

Oates emphasises in *"Child Abuse - what eventually happens"* (1985) that before we can attempt to delineate consequences, we should note that prior to 1946 child abuse was largely professionally unrecognized. There were rare and isolated studies such as that by Ambrose Tardieu in 1869 in which he reported on fifty two children battered to death.

This very long period was followed by an early scientific phase during which a number of hitherto unidentified syndromes of broken bones, bleeding and bruising were reported in journal articles between 1946 and 1962. However the significance of these unusual injuries was rarely appreciated. The next phase in "scientific" awareness came with Henry Kempe's classic paper in 1962 in which the term "battered child syndrome" was coined to direct attention to the seriousness of the problem.

The term battered child suggests a clear cut entity. There are, however, many difficulties in definition.

Child abuse is an extremely complex phenomenon ranging from fatal assult, to deprivation of food or affection and also includes the various forms of psychological and sexual abuse. This makes for difficulties in comparing the results of different researchers.

It is sometimes difficult to draw the line between what is acceptable punishment (if such a thing exists) and physical abuse. Anthropologists point out that whilst at one level childrearing practices that are acceptable in one cultural group may be unacceptable in another, at a second level there are more extreme instances of behaviour toward children that are recognised as abusing and unacceptable by all cultures.

There is as well, some danger in simply looking at physical injuries, however horrific, which often do depend on the circumstances surrounding the violent act. If one simply looks at the physical injuries the problem in the family may be missed altogether.

However, it is the act of violence on the part of the parent or other that is the constant feature rather than the visible injury. This is of particular relevance in looking at the area of emotional and psychological abuse. This is far more difficult to define; the scars are less obvious and it is probably more common than the combined total of child physical and sexual abuse.

Gil (1970) attempts to overcome the problem of being too specific by defining abuse as any force that compromises a child's capacity to achieve his/her physical and psychological potential.

Kempe and Helfer (1974) define the battered child as any child who receives non-accidental physical injury (or injuries) as a result of acts (or omissions) on the part of his/her parents or guardians.

Regarding sexual abuse in particular, Kempe offers a definition of this form of abuse as the "involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend, to which they are unable to give informed consent or that violates the social taboo of family roles ... children and adolescents are exploited, he says, because sexual abuse robs them of the developmentally determined control over their own bodies and of their own preference, with increasing maturity for sexual partners on an equal basis."

INCIDENCE

In 1971, Kempe estimated that the incidence of child abuse in the United States was 6 live cases/1000 live births. Because of clinicians' difficulty and reluctance in making the diagnosis, the actual incidence is probably much higher than reported.

In 1979 over 1.1 million children were reported to the authorities in the United States as suspected victims of child abuse or neglect. The incidence of reported cases in Australia and New Zealand is also increasing.

In N.S.W. an amendment to The Child Welfare Act in 1977 made it mandatory for medical practitioners to notify cases of child abuse. In the first year after the amendment, 887 cases were notified. In 1982 this number has increased to 2,900, an incidence of 23 cases/ 10,000 children under 14 years. It was estimated that by 1985 the number of cases reported in N.S.W. (a state with a population of 5.5 million) would have risen to over 10,000.

In looking at incidence one must be aware of the many problems to do with under-reporting, over-reporting, differences in definition, etc..

It is also worth noting that while family practitioners are in a unique position to detect child abuse and, more importantly, to detect developing stresses in the family that may lead to abuse, the great majority of child abuse reports in fact come from hospitals.

Kempe and Helfer (1974) estimated that 15% of children under 5 years of age who attend hospital casualty departments are likely to have inflicted injuries.

A study from Royal Alexandra Hospital for Children in Sydney, in 1977, showed that 40% of children under 5 years of age presenting to the casualty department with injuries or burns had features strongly suggestive of child abuse.

The actual incidence of sexual abuse of children is almost impossible to determine. One Australian researcher has said that general research into child abuse would lead us to expect 2,000 cases of sexual abuse each year in New South Wales.

As Oates (1982) points out, although there is a lack of clarity in the definition of child abuse and its true incidence, the important conclusion that should be drawn from available studies is that child abuse is very prevalent. It is far more prevalent than many other diseases to which considerable paediatric time and resources are devoted.

Consequences of Abuse

Information about consequences is derived from two main sources - systematic retrospective and prospective studies of groups of abused children and details obtained via clinical and psychotherapeutic work with child and adult patients.

Other important information can be obtained from literature and biographical sources and writers such as the Swiss psycho-analyst Alice Miller (1984) have been able to make very valuable interpretive use of such available material.

Systematic studies are, however, few in number and because of different populations studied, differences in the source of samples, and loss of follow up (families often being very difficult to locate after several years because of high mobility), careful interpretation is necessary.

Little attention was paid in the earlier literature to the long term effects of abuse on the child - writers tending to concentrate on injuries and speculating on parental characteristics that led to abuse. Oates (1985) notes it was not until the paper by Elmer and Gregg in 1967 that the high degree of neurological, developmental and psychological disabilities in the abused child was fully realized. They reviewed 20 children out of an original sample of 50 at a mean interval of 5 years after the abuse. They found that 40% were emotionally disturbed and 50% had an I.Q. below 80.

Writing in "Child Abuse - a Community Concern" (Oates 1982), H.P. Martin reviews what is known about the consequences of abuse to children and looks at studies examining how abuse affects infants and children as well as what effects may be seen in the adolescent and adult, who were abused in childhood. He groups consequences to children under three main headings; health problems, neuro-developmental disabilities and emotional problems.

Health Problems

Apart from obvious physical damage, under health, anaemia and under nutrition are significantly observed corollaries of abuse. Just as well documented are an increased risk of infection, dental problems, visual and hearing deficits, greater risk of accidental injury and inadequate past health care - all are possible consequences of an abusive environment. Some health problems actually precede abuse such as lower birth weight, prematurity and a higher incidence of neurological abnormalities. It is possible that these factors may predispose to or precipitate abuse in certain families. (See Klaus & Kennell, Material-Infant Bonding, 1979.)

Neuro-Developmental Disabilities

Under neuro-developmental disabilities data from a number of sources demonstrate that mistreated children are at considerable risk of mental retardation, brain damage, language delays, perceptuo-motor immaturity and learning disabilities.

The earliest descriptions of seriously abused children (in Oates) reported a developmental morbidity of 88%. Subsequent studies have also documented retardation and other developmental disabilities in large percentages of abused children.

Whilst data are lacking to enable an accurate prognosis of the chances of developmental disability in an individual abused child, there seems little question that what eventually happens to a large number of children is that they are handicapped by some variety of neuro-developmental delay. Retardation, learning disabilities, motor delay and incoordination (both gross and fine motor) and language disability are common problems that abused children must endure.

Emotional Problems

In the area of emotional sequelae, Martin cautions that no one specific personality profile is seen in abused children. Rather, it seems the child's personality will be shaped by a number of factors including the type of parents, the developmental stage when abuse occurred, innate factors within the child, who the perpetrator was, the type of parenting behaviour to which the child was exposed, and the type of treatment offered the child and family.

However, when another researcher, Kinard (1982), looked at a number of studies, he found that despite methodological difficulties, most of the reports agreed that abused children are usually aggressive, have poor self concept, lack a capacity to trust, have deviant interpersonal relationships and detachment behaviours.

Martin and Beezley's (1977) description of 50 abused children emphasized extremes of behaviour. For example, the child may have excessive stranger anxiety or may in fact be indiscriminate in affection to all; there may be oppositional behaviour or co-operative hurt obsequious responses. The aggressiveness of abused children has been emphasized frequently; however, it is worth noting that this may present in different forms. Aside from antisocial responses aggression may well be turned inwardly as clearly demonstrated by an increased incidence of depression, suicide, self mutilative and self-abusive behaviour in abused children.

As Martin says, given time to listen to one's own intuition, one can't help feeling that mistreated children will grow up to be adults who may threaten the peacefulness and security of their society. One cannot help but feel that there may be a warping of children's lives by being unloved, neglected and physically abused. One cannot help but feel that such children's chances of growing up to be unhappy adults, who may play out their anger and hurt by striking out at others, is very high.

Kinard's conclusions based on his review of a number of studies (in Oates, p.185) would seem to give substance to these intuitive feelings - that abused children are likely to be aggressive in one form or other, have poor self-concepts, have deviant object relations and an impaired ability to trust and attach to people.

Children can manifest different characteristics in relation to the pattern of maltreatment that has taken place. In a 4 year prospective study of 267 abusive families, Egeland and colleagues (1981) found that physically abused children were distractible, lacked persistence, ego control and enthusiasm, and experienced considerable negative emotions. Those children whose mothers were psychologically unavailable showed a marked increase in maladaptive patterns of functioning.

Neglected children had considerable difficulty in dealing with the various tasks required in the pre-school situation because of lack of self-esteem.

Abused Children and Their Families

This study emphasizes that child abuse and neglect covers a wide range of behaviours with the outcomes depending considerably on the initial problems and family characteristics. It also highlights the need, as Oates and others point out, for a careful assessment of the child, as well as the family, so that a specific treatment program to meet the child's needs can be formulated.

In Oates' study of long term effects of physical abuse and the allied failure to thrive syndrome, he followed up 39 out of an original 109 abused children on an average of 5½ years after diagnosis. He found that the abused children had fewer friends and played with their friends less frequently than comparison children. This apathetic, withdrawn behaviour at the time of presentation and the inability to develop basic trust (in the Ericksonian sense) persist long after the initial incident. Oates wondered if these children's lower job ambitions (compared to controls) may also indicate their inability to reflect the high and unrealistic expectations of some abusing parents for their children.

It is worth pondering on this somewhat paradoxical situation a little more.

De Mause (1974) feels that when an adult is face to face with a child who needs something, three major psychological reactions are possible. Firstly, he or she can use the child as a vehicle for the projection of the contents of his or her own unconscious (the "projective reaction").

Secondly, he or she can use the child as a substitute for an adult figure important in his or her own childhood (the "reversal reaction"); and thirdly, he or she can empathize with the child's needs and act to satisfy them (the "empathic reaction"). I suppose that very much we would all want to aspire to the "empathic reaction" but inevitably the 1st and 2nd reactions, if we are honest, are a part of our unconscious relationship with our children. Here perhaps one might start to see that in talking about referred abuse we are really talking about degrees.

In illustrating the reversal reactions, de Mause gives an account of one worker's observations during a home visit to an abusing mother ... "I remember watching an 18 month old soothe her mother who was in a state of anxiety and tears. First she put down the bottle she was sucking. Then she moved about in such a way that she could approach, then touch and eventually calm her mother down (something I, comments the worker, had not been able to begin to do). When she sensed her mother was comfortable again, she walked across the room, lay down, picked up her bottle and started sucking it again". (p.162).

As Richard Goldstone writes in the Basic Handbook of Child Psychiatry, Vol. II (1979), there is often a strange and confusing conjunction of feelings towards the child, by the abusing parent, coloured by the first two reactions above. Abused children can therefore be both loved and hated by their parents and their bodies then bear the stigmata of the extreme ambivalence with which they have been perceived and cared for by them. Often, strangely, it seems that abused children are raised in the warmth of parental wrath which serves them better than neglect or deprivation by parents who are more indifferent to their humanity.

Via the reactions mentioned, parents who abuse their children frequently suffer from an inability to accept the fact of their parenthood.

They look to the child to confirm the correctness, the validity, of their status as parents. Here the question of discipline can assume an obsessional importance to them. The child conceived is often, unconsciously, born to a grand name, chosen to reflect high hopes which can then be quickly dashed by the child's failure to realize parental aspirations. Child abuse, then, says Goldstone, is an act that reflects the human capacity to entertain two intense and mutually contradictory emotions simultaneously. There is an essential psycho-pathological core to the act of physical violence that distinguishes child abuse. It consists precisely of this parental capacity to project distorted perceptions onto their young and to respond impulsively in accordance with their own "delusions". Within the spectrum of human violence then, it lies somewhere between suicide and homicide.

Retrospective Studies of Abused Children

When Martin goes on to look at studies of adolescents and adults who were abused in childhood, he notes that there are no prospective longitudinal studies of abused children which follow them into adult life. One is left with retrospective studies of special groups such as delinquents, criminals, school drop outs and drug addicts.

It would seem that there is a substantial risk of abused children taking one of these socially deviant pathways. In going further and looking at the generational transmission of abuse and neglect, Steele and Pollock (1968) feel able to say that almost all the abusive adults seen by them were mistreated as children.

One must keep in mind, of course, that studies reflect trends rather than inevitability. For example, in one study of mothers who mistreated premature infants, it was found that a significantly greater proportion of these mothers had been mistreated as infants. However, only about 20% of women with histories of being abused, mistreated their children - at least during the 1st year of life.

Observing consequences of abuse in infants and children does have prognostic value in considering the later adolescent and adult years of life. Impaired learning, retardation, language and motor disabilities will not spontaneously disappear in adulthood.

A most distressing long term effect of maltreatment, often explored in later clinical work with adults, is a life of incompetence and failure. Such adults, as Martin points out repeatedly, gave histories of job failures, school failures, and repeated failures in marriages or romantic liaisons. This would follow if low self esteem, impaired interpersonal relationships and a sense of an external locus of control, persist from childhood.

If, as Steele feels, most mistreated children who grow up to abuse are borderline or narcissistic personality disordered people, it follows that lack of competence or success should prevail in their lives.

This is a grim picture. Loss occasioned by abuse in childhood has a snowball effect - if not exhibited openly, then certainly apparent as a poverty or distortion of the adults subsequent inner psychic experience.

There are of course, as Martin, Oates and others point out, always a subset of persons who were exposed to stressful and noxious experiences who do quite well. But again, the price that some may pay, is in developing characteristics that may be painful to them but not viewed as deviant to society.

Some individuals may be fortunate in experiencing very potent therapeutic experiences, or in finding some parent surrogate or alternate life experience which helps mute the effects of abusive parenting. In others the abuse may in fact follow a period of loving parenting, e.g., when a parent or family undergo some later life crisis. This may in fact leave the individual relatively unscathed.

In examining the factors in abuse one wonders about the innate contribution of particular children to the abusive interaction. This is in no way meant to shift blame and responsibility from the adult but to help understand the interplay of factors that may be present. For example, Brazelton's work (1973) on the variability of newborns to noxious stimuli suggests that inborn temperamental traits may also make the individual more or less vulnerable to abuse.

Martin and others make the point that it is naive and fatalistic to assume that nothing can make a difference in what eventually happens to an abused child. Even primate research shows the modifying effect of a particular social surround. Even when a gorilla mother was poorly parented herself, this mother's abuse and neglect decrease when another familiar adult is put in the cage with her and her infant.

It must be emphasized (Oates 1985) that it is less likely to be the incident of physical abuse that leads to problems, than the continuation of the disturbed environment in which the child lives. The crucial factor in determining a poor outcome for the child seems to be the continuation of an unsatisfactory environment.

In reviewing the long term effects of early experience, Michael Rutter (1980) concludes that it is possible for a major improvement in the environment in middle childhood to lead to substantial increases in I.Q., speech and language development, although some residual consequences of early adverse experience may remain. This is most pertinent in terms of psychologicaland psychosexual development in children and adolescents who have been sexually abused, and it is to this group that I would like to turn our attention.

Sexual Abuse

Can I offer two comments - in isolation - as theme markers for the material that follows.

The first is from de Mause who comments that in sexual abuse as in physical abuse, the child is often only an incidental victim, a measure of the role he or she plays in the defence system of the adult.

The second comment is from Alice Miller (1984) who argues that sexual seduction of children is just one form of exploitation of children in which a misuse of power rather than sex is the central dynamic in the abuse.

Steele and Allexander, writing in Mrazek and Kempe's valuable publication "Sexually Abused Children and Their Families" (1981) emphasize the current fact that we do not know nearly enough about the long term effects of sexual abuse. There are few retrospective evaluations and even fewer prospective studies.

A subtle and prevalent reason for this is the reluctance of sexual abuse victims to discuss their problems, even many years after the abuse. This reluctance is frequently abetted by professionals who for reasons of their own, are hesitant to deal with the problems of sexual abuse - even during long term therapy and counselling.

Reluctance to discuss and failure of disclosure are often related to the very strong admonition to the child victim never to tell about his or her experience, often accompanied by the threat of severe punishment if this prohibition is broken. Also involved is the great personal insecurity of the sexual abuse victim and the fear that revelation will stir up unbearable shame, guilt and social disapproval. There are losses at many levels for the child victim of this type of abuse.

Later effects cannot simply be related to the sexual nature of the abuse. The impact on the child will differ according to age, stage of psychosocial development, the nature of the abusive act, the frequency of repetition, the amount of aggression involved, and the relationship of the abuser to the abused.

A consistent impression from such studies as there are, and our own observation, is, that sexual abuse is likely to occur earlier, more frequently, and often with more accompanying aggression or physical abuse, in the multiproblem family in which all interpersonal relationships are likely to be more disturbed and distorted. Such families are spread across the socio-economic spectrum.

Physical and sexual abuse may occur concurrently or quite separately at any time in children's lives. In the first two or three years physical abuse is more common. When occurring together, it is usually the physical abuse that is reported and draws attention to the latter.

In sexual abuse, as in physical abuse, it is the emotional climate in which the sexual trauma occurred that is the most potent instigator or long lasting effects.

A common impression and finding is that less severe sexual abuse occurring in the bosom of a disturbed family is much more traumatic than the sexual abuse of a child perpetrated with greater aggression, by a stranger completely outside the family. In a healthy family a child abused by an outsider can be immediately comforted and supported and helped to deal with the trauma thereby minimizing later difficulties. There is a danger in generalizing here, however, as the psychological consequences of stranger assault may well require more than just family support.

Possible Psychological Symptoms and Sequelae to Sexual Abuse in the Short Term

It is worth noting that these often subtle symptoms may indicate hitherto undisclosed abuse, especially when they are the initial reason for presentation to child agencies.

(a) In the child under 5 years of age, one might see aggressive sexual abuse resulting in fear states and night terrors, clinging behaviour and some form of developmental regression.

(b) In the school-age child, the subtle clinical manifestations may include sudden onset of anxiety, fear, depression, insomnia, hysteria, sudden massive weight loss or weight gain, sudden school failure, truancy or running away.

(c) In adolescence, serious rebellion, particularly against the mother, is often the major symptom.

As children grow older, says Kempe (1978), we often find more serious delinquency, accompanied by hugh loss of self esteem. Prostitution, chronic depression, social isolation, increasing rebellion and running away are all possible outcomes. Fifty per cent of female runaways in one study gave sexual molestation as a reason for fleeing (Nakashima 1977). Youngsters may come to the attention of the health care system or the law only through pregnancy, prostitution, V.D., drug abuse or anti-social behaviour.

These symptoms may not be specific to any one particular group of sexual offences. For example, Nakashima feels that there does not appear to be any set of symptoms or complaints peculiar to incest. Victims of incest may come to the attention of medical personnel with any of the abovementioned symptoms such as vague somatic symptoms, anxiety and depression, poor school performance and a variety of acting out behaviours.

Burgess et al (1977), make the very pertinent comment that misinterpretation of behavioural signs is an extremely common error made by personnel who are trying to determine if sexual assult of a child actually occurred. Children can exhibit an entire gamut of behaviour in response to a sexual assult, ranging from the negative to the positive. Unsophisticated observers, they add, may note calm and unconcerned behaviour or outright denial of the situation, or positive response by the child to the suspected perpetrator. (All these behaviours have frequently been observed in child victims at Royal Alexandra Hospital for Children where sexual assault has been suspected. Observers may mistakenly conclude that no assault could have occurred because of the child's reaction.)

The degree of gratification and secondary gain for the child as a result of the sexual relationship must also be assessed. In many cases, the sexual relationship may have represented an avenue whereby emotional needs from an important adult could be maintained. This certainly seemed the case in Helen Connell's (1978) group of sexually abused children between the ages of 5 and 12 who all came from backgrounds lacking in emotional warmth. Here it seemed, sexual approaches were allowed in order to gain adult attention.

Burgess adds that termination of such relationships may well result in a sense of loss for the victim, especially if the offender was a relative or even a parent. The child's feelings of grief or loss may be aggravated by temporary or permanent separation from the offender. This does not condone such activity. As described, in many instances, the child may unconsciously have had to bargain acquiescence for his or her emotional attachment needs. The aim of intervention should be to maintain the latter if at all possible, whilst preventing the former. Anthony Storr adds another important factor here: "If the seduction of the child does not result in the implantation of the fear of sexuality, it may cause the premature arousal of desire, which the child then finds it hard to fulfil".

Some children, he feels, especially after a long continued sexual association with an adult, become deprived and emotionally disturbed when such an association ends; when they grow up they may be led to repeat the pattern by themselves seducing another child. (See also Stoller - "Perversion. The Erotic Form of Hatred" (1977).

Finally, some children may feel very guilty about their role in such a sexual relationship. The important factor here seems to be the child's age and developmental level, as well as the expressed reaction of parents and significant others; for example, siblings, peers and teachers. The child whose parents react by blaming the "victim" may be made to feel guilty on many levels.

A review of 70 victims over a 12 month period (90% female) found that fear of parents' reactions increased with age and that the tendency to self-blame increased with age. They claim that the victim's recovery from the emotional trauma after an assult was closely related, not surprisingly, to the quality of the parent-child reaction.

Many authors emphasise that pre-adolescent and adolescent victims are most especially vulnerable here. In this group, the incident may occur in the midst of an already conflict-ridden parent-child relationship, together with the reawakening of sexual drives. Here there is a particular likelihood that the adolescent girl may withhold information as many previous women victims in later years reveal.

The need for sensitivity is especially acute in cases of incest. Here the issues of divided loyalty and irresolution of conflict are central. The risks to the child especially are enormous. Summit and Kryso (1978), in fact, talk of the child's possible betrayal on three levels. First, the feeling of betrayal by the offender-parent, by whom the child may have been alternately demeaned and courted. Secondly, in turning to the other parent or other members of the family, the child may be accused of lying or condemned for "seducing" the parent. Even if the story is accepted, the other parent may fail to act in the child's defence. The third level of betrayal may come from the helping institutions. The child may be punished by the demand for explicit indiscriminating testimony and sometimes regarded as depraved and "ruined" through her participation. The parent or relative may deny everything, forcing the girl into an adversary role with its inherent risks of offender acquittal, family disintegration and isolation, and moral condemnation of the child.

Despite the complex dynamics operating in incest and the often raised question of complicity by the child, it is important to keep in mind that the offending parent, as Summit and Kryso point out, is the key to the disturbed dynamics and, as the adult authority figure, is responsible for the choice to eroticize the relationship with the child, whatever the quality of their pre-existing relationship. They feel that, regardless of the parent's motivation and of the possible contribution of the child, it is the therapist's duty to emphasize the offender's responsibility.

Many of these features have been found in early reviews of sexually abused children referred to the Royal Alexandra Hospital for Children sexual assault centre since its inception in 1978. In the first 12 months of operation of the centre, 63 children were referred, 53 female and 10 male. In 4 cases more than one sibling was involved. The average age was $7\frac{1}{2}$. 13 children were victims of incest, 11 children showed some evidence of physical injury and 21 children demonstrated clear evidence of immediate or short term psychological symptoms.

In a later study at Royal Alexandra Hospital for Children, in 80% of cases, referred families of origin were found to be severely disrupted by divorce and other forms of separation - long before abuse was recorded. Most of the children came from crowded or substandard housing areas.

A review of almost forty cases referred for psychiatric assessment at one clinic revealed a continuum of severity from the somewhat bizarre referral of members of a boys' drama school, reputedly molested by the teacher, to one case of child murder by an assailant with a previous history of suspected long-term sexual molestation. Sadism and obvious violence was evident in at least three other cases, without, however, evidence of severe physical damage at the time of examination.

One striking observation was that of an inter-generational recurrence of sexual abuse. In at least five instances, a current episode of assult of a child brought back for the mother her own very vivid memories of earlier similar experiences of sexual abuse. The subsequent and usually too-abbreviated intervention often involved dealing with these memories and their tendency to complicate further, via projection, the difficulties for both parent and child.

For example, in one case an 11 year old boy complained of molestation by his grandfather and mother's de facto. The boy's grandmother, to whom he complained, became enraged and "broadcast" the news to the boy's mother and other family members. The mother was understandably distressed but what distressed her most was her mother's prompt and enraged response in <u>this</u> instance. She was bitterly

reminded of this same woman's failure to "sound the alarm" when as a child she had been similarly molested and raped, not only by the same man, i.e., the grandfather, but also by others brought home by him. This woman had already undergone immense suffering requiring long-term psychiatric treatment. These memories were now reawakened by her child's alleged experience. She felt her mother to be a "double villain", tearing her current relationships apart (her de facto leaving soon afterwards), by her "evangelistic" revelation, having already failed to protect her as a child.

Further victimization by a parent of an already abused child was seen in one case where a mother, learning of her daughter's alleged sexual abuse by male relatives whilst on holidays, accused the daughter of complicity and became almost homicidal in her rage against the child. This child presented initially to Casualty as physically injured and the mother, when confronted, admitted to abuse and though able to talk through her rage and "disappointment" in her daughter, eventually requested the child be placed for fear of losing control. The little girl herself was obviously distressed, physically abused and depressed.

Again, it seemed projective mechanisms based on likely similar experiences operated within this mother in precipitating such a massive and primitive response. This could not be dealt with solely by counselling. The mother's request for containment and preventive separation was acted on after much consideration and co-operation with Youth and Community Services.

As well as the use of projective techniques in the assessment of these children, many seemed especially able to discuss their subsequent "post-assault" dreams, frequently with greater ease than the assault incident in question. On a number of occasions, it was possible to work back from their dreams to memories of the actual event and especially fears of repetition and retaliation. Unfortunately, in many cases, despite strong grounds for continued therapeutic contact, this was not possible and highlighted again the inadequacy of the then available facilities and especially the lack of time and opportunity for liaison with local community agencies.

In one case, involvement with an older male neighbour appeared to be the result of a little girl seeking out substitute paternal affection; an attempt perhaps to deal with the recent death of her father. The offender here was, in fact, approximately the same age as her father at the time of his death. This and other cases emphasised the complex dynamics that may operate and that need to be looked for in sometimes overly straight-forward incidents.

Referrals have often unearthed other family difficulties which one could postulate as operative in placing the child "at risk" of accidental assault. In one family, general preoccupation with a much admired father's struggle with a terminal illness seemed significant. In other families, one in particular, long-term lack of adequate supervision and poor general emotional and physical care operated in the dynamics of the subsequent assault.

The potential for disintegration of an extended family system, following the disclosure of sexual abuse, was dramatically demonstrated by one case. Here a pre-teen girl was assaulted by a relative, who then threatened to kill her if she "told". This girl silently coped with her feelings for some months, including not only her own fears of retaliation, but fears that this same man might involve her youngest sister, as in fact he had, it seemed, similarly assaulted her eldest sister. It was only when particularly aware and caring school authorities noted this girl's atypical lack of concentration, social withdrawal and academic decline, that she was provided with a safe forum in which to disclose her considerable fears.

Police and medical agencies were subsequently involved but unfortunately immediate counselling was not provided. This family was referred to the clinic some months later via another social contact. By this time however, the now divided elements of this once closely united family had become locked in a violent cross-accusatory legal struggle. The girl's father battled with a wish to kill the relative in question. The mother had become overly protective and restrictive of her very intelligent daughter. The latter continued to suffer difficulty in concentration, period irregularity and fear of long-term gynaecological damage, together with repetitive nightmares concerning murderous retaliation by her relative.

This case particularly demonstrated the problem where a counselling service was not interposed before or associated with the implementation of a purely legal solution.

Among the different ways of misusing a child, according to Alice Miller (1984), sexual abuse is of particular significance, stemming as it does from the major role sexuality plays in our body and from the confusion and distortion surrounding it in our society.

Human beings have strong sexual drives in different forms and at different stages of their lives and there is always a potential for these drives to be activated and utilized to express other conflicts and attempts to solve them. The essence of the abusive element in the sexual activity is the misuse of the immature child by the adult for the solving of problems and satisfying of adult needs, whilst disregarding the needs and developmental state of the child. The adult instigator takes advantage of the child's own normal sexual responsiveness, his/her wishes to please and obedience to authority. At the same time, other important caretakers condone the behaviour, do not protect the child and disregard the child's complaints.

Whilst there are similarities between the consequences of physical abuse and sexual abuse, in the latter the abuse is more likely to take place surreptitiously and under darkness; the likelihood, as Miller puts it, of finding the help of a courageous witness who can facilitate the integration of what has happened, is much less.

Children cannot achieve integration by themselves. They often have no choice but to repress the experience because the pain caused by their fear, isolation, betrayed expectation of receiving love, helplessness and feelings of shame and guilt is unbearable.

There is agreement that it is especially common to find in sexually abused children and adolescents feelings of having been exploited, abandoned and never listened to. There is an awareness either consciously or unconsciously, that they were used to solve parental difficulties rather than having been cared for, in terms of their needs for affection, in an age-appropriate fashion.

Furthermore, the puzzling silence on the part of the adult about his deeds and the moral principles and prohibitions he proclaims by light of day, create an intolerable confusion in the child that must often be done away with by means of repression.

More than this, if children are talked out of what they perceived (a not uncommon finding in the work at Royal Alexandra Hospital for Children), then the experience they undergo will later be seen in, as Miller put it, "a diffuse hazy light; its reality will remain uncertain and indistinct, laden with feelings of guilt and shame and as adults these children will either know nothing of what happened or will question their memory of it. This is more likely to be the case if the abuse occurred in early childhood".

Since very young children often do not find support within their own self or a mirror in the eyes of a witness, they must deny the truth.

In later life the adult patient may then repeatedly and unconsciously re-enact this reality, may tell the story by way of symptoms, including physical ones, and may hope that the whole thing is a matter of fantasy.

In this way often variations in sexual dysfunctin (e.g. frigidity, vaginismus, nymphomania and promiscuity and in men impotence, premature ejaculation, exhibitionism and compulsive sexual conquests) and abnormal sexual behaviours (e.g. the perversions) which occur in later life, are essentially maladaptive attempts to compensate for, or somehow adapt to, the distortions created in a developing psyche by the sexual exploitations and emotional disregard suffered via the abuse.

The consequences of sexual abuse, however, are not restricted to problems in one's sexual life. They impair the development of the self and an autonomous personality.

One sees particularly in therapeutic work with adults, who were victims, tragic feelings of inferiority, non-integrated identity, poor basic trust, repressed anger, unresolved identifications and fixations and profound difficulties in establishing and maintaining warm, successful human relationships.

There are several dynamic reasons, outlined by Miller (1984), as to why these consequences are likely.

Firstly, to have one's helplessness and total dependency taken advantage of, particularly by the person one loves, by one's mother or father at a very early age, soon produces an interlinking of love and hate.

Secondly, because anger toward the loved person cannot be expressed for fear of losing that person, and therefore cannot be lived out, ambivalence, the interlinking of love and hate, remains an important characteristic of later object (personal) relationships.

Many, for instance, cannot then imagine that love is possible at all without suffering and sacrifice, without fear of being abused, without being hurt or humiliated.

Thirdly, since the fact of abuse must often be repressed for the sake of survival, all knowledge that might threaten to undo this repression must be warded off by every possible means, which ultimately results in an impoverishment of the personality and a loss of vital roots manifested, for example, in depression.

Fourthly, the consequences of a trauma are not eliminated by repressing it but are actually reinforced. The inability to remember the trauma, to articulate it (i.e., to be able to communicate these feelings to a supportive person who believes you) creates the need to articulate it in the form of a repetition-compulsion. For example, it is not uncommon to find men and women, who were physically and sexually abused as children, repeatedly involved with sexual or marital partners who abuse them physically or emotionally.

Fifthly, the unremembered plight of being at someone else's mercy and being abused by a loved object, is perpetuated in a passive or an active role (i.e., victim or persecutor) or alternately in each.

Sixthly, one of the simplest and completely unnoticed forms of perpetuation of the active role, is in the abuse of a child, often very subtle, for one's own needs, which sometimes are all the more urgent and uncontrollable the more deeply repressed the original trauma.

It is difficult to write or talk about child abuse without taking on a moralizing tone. It is so natural to feel outraged at the adult who beats a child and pity for the helpless child that, even with a great deal of understanding of human nature, one is tempted almost to condemn the adult for being cruel and brutal. But where will you find human beings who are only good or only cruel? The reasons why parents mistreat their children have less to do with character and temperament than with the fact that they may have been mistreated, in one form or another, and were not permitted to defend themselves as children.

In the less repressed, remembered instances of sexual abuse, shame, guilt and fear of social disapproval make it even more difficult to cope with the underlying feelings of helplessness and fear. (See A. Miller, "Thou Shalt not be Aware", p.322-324.)

Based on a paper presented at a seminar at the Royal North Shore Hospital, June, 1986.

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ISBN 0 947193 03 0